Appendix 7

Wisconsin Medicaid Pharmaceutical Care Reason Codes With Billing Information

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, Pharmaceutical Care (PC) Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AD (60) — Based on review of the recipient's drug regimen, the pharmacist-determined treatment may be enhanced by addition of a new drug to the existing drug regimen.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AD-M0-1E+ + Requires linked drug National Drug Code (NDC), same date of service (DOS).	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Nature of problem that additional drug may correct. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason AD (60) PC dispensing fees per recipient, per year. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AN (10) — Prescription order forgery suspected.	M0 (22) — Prescriber contacted. R0 (29) — Pharmacist contacted other source or contact (e.g., police or another pharmacy). TC (15) — Payer/processor contacted. To submit Action code R0, prescriber must be contacted and concur that the prescription order should not be filled.	2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: AN-M0-2A AN-R0-2A AN-TC-2A	Document: • Date of intervention. • List prescription (Rx) orders questioned. Include drug, quantity, directions, and prescriber name. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Basis for suspicion of forgery. • Summary of any communication with prescriber, recipient, or other contact. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required for PC dispensing fee. • No more than two Reason (10) PC dispensing fees per recipient, per year. • Level 14 = maximum PC dispensing fee. • Not billable for nursing home residents.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AR (61) — Based on information obtained about the recipient's medical condition, the pharmacist has determined the recipient may be experiencing an adverse drug reaction.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AR-M0-1C+ AR-M0-1D+ AR-M0-1E+ AR-M0-1K+ AR-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of adverse reaction. • Identify drug(s) involved. • Summary of and therapeutic basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason AR (61) PC dispensing fees per recipient, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
AT (40) — Recipient's drug regimen includes multiple drugs that may cause additive toxicity or side effects according to medical literature.	M0 (22) — Prescriber contacted. RT (30) — Pharmacist recommended lab test to the physician.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: AT-M0-1C+ AT-M0-1D+ AT-M0-1E+ AT-M0-1F+ AT-M0-1K+ AT-M0-2A AT-RT-1C+ AT-RT-1D+ AT-RT-1E+ AT-RT-1F+ AT-RT-1K+ AT-RT-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of problem caused by multiple drugs. • Identify drugs. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason AT (40) PC dispensing fees per recipient, per drug combination, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
CD (71) — New diagnosis or new drug therapy — ASTHMA. The pharmacist has determined that additional education or counseling is necessary.	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 Allowed PC dispensing fee code combinations: CD-M0-1C+ CD-M0-1D+ CD-M0-1E+ CD-M0-1K+ CD-M0-2A CD-PE-3M+ CD-PE-3K+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Verify new diagnosis. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify new drug therapy. • Summary of information or education provided in each session. • Prepare and maintain a therapeutic work-up and report to be made available to the prescriber on request. • Pharmacist helped the recipient understand all recipient-specific, drug-related problems. • Desired therapeutic outcome(s) expected. • Plan for monitoring the recipient. • R.Ph. identity. Limits: • A maximum of six Reason CD (71) PC dispensing fees per recipient, per year. • Level 14 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
CS (63) — Based on recipient complaint or known or suspected symptom(s), the pharmacist initiated drug regimen review or recipient consultation. The pharmacist determined an actual or potential medical problem, other than adverse drug reaction, may exist.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan. M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: CS-AS-3K+ CS-M0-1C+ CS-M0-1D+ CS-M0-1E+ CS-M0-1K+ CS-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Recipient complaints or symptom(s). • Process, including medical literature, used to determine actual or potential problem. • Description of therapeutic basis for the possible problem. • Summary of outcome, including summary of any communication, with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of one Reason CS (63) PC dispensing fee per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee. Notes: Rule out use of other PC Reason Codes which may be more specific to the problem before using this code.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DA (41) — Recipient has a known or suspected allergy to this drug or drug with similar pharmacological effects resulted in atypical reactions.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DA-M0-1E+ DA-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of allergy problem. • Identify drug. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DA (41) PC dispensing fees per recipient, per drug, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DD (44) — Recipient's drug regimen includes multiple drugs which may result in unintended pharmacological response according to medical literature.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DD-M0-1C+ DD-M0-1E+ DD-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug(s). • Nature of problem caused by multiple drugs. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DD (44) PC dispensing fees per recipient, per drug combination, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DI (45) — IV drug incompatibility detected.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: DI-M0-1E+ DI-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Nature of compatibility problem. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DI (45) PC dispensing fees per recipient, per drug, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
DM (65) — Possible drug misuse.	M0 (22) — Prescriber contacted. 1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: DM-M0-1C+ DM-M0-1D+ DM-M0-1E+ DM-M0-1F+ DM-M0-1K+ DM-M0-2A DM-M0-3M+ DM-M0-3K+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Description of possible problem. • Summary of outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason DM (65) PC dispensing fees per recipient, per year. • Not billable for nursing home residents. Note: Rule out use of other PC Reason codes which may be more specific to the problem before using this code.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
ER (20) — Early refill. —Compliance problem suspected. — Refill before 75% of previous prescription should be consumed, based on predicted days' supply (abuse not suspected). —Do not use this code if abuse is suspected or documented. See Reason code DM (65).	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: ER-M0-1C+ ER-M0-1D+ ER-M0-1F+ ER-M0-1K+ ER-M0-2A ER-PE-3M+ ER-PE-3K+ ER-PE-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Dates for previous two refills. • Expected date for this refill. • Number of days early, percent early on days' supply. • Determined reason for early refill request. • Outcome, including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. Limits: • Maximum four Reason ER (20) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • A PC dispensing fee may *not* be claimed under this code if the early refill is determined to be due to something other than a compliance problem (e.g., recipient leaving town, early refill for convenience, lost medication). • Max PC dispensing fee: Level 13 on Action code M0, level 12 on Action code PE. • Not billable for nursing facility residents.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
EX (21) — Prescribed quantity appears excessive for the recipient's condition or predicted medical need according to medical literature (abuse not suspected).	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Filled, dose form change. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: EX-M0-1C+ EX-M0-1D+ EX-M0-1E+ EX-M0-1F+ EX-M0-1K+ EX-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Expected quantity for recipient's condition. • Determined reason for prescribed quantity. • Outcome including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required. • Maximum of two Reason EX (21) PC dispensing fees per recipient, per drug, per year. • Do not use this code if abuse is suspected or documented. See Reason code DM (65). • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee. Note: Titration or other dose adjustment must first be ruled out.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
HD (23) — Prescribed dose is above the standard range for patient's condition according to the literature (abuse not suspected).	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: HD-M0-1C+ HD-M0-1D+ HD-M0-1E+ HD-M0-1K+ HD-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason HD (23) PC dispensing fees per recipient, per year. • Do not use this code if abuse is suspected or documented. See Reason code DM (65). • Result code 2A (30) may only be used when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LD (33) — Prescribed dose may be insufficient to treat this recipient's medical condition according to medical literature. —Titration ruled out.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: LD-M0-1C+ LD-M0-1D+ LD-M0-1E+ LD-M0-1F+ LD-M0-1K+ LD-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected dose. • Source of minimum recommendation. • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason LD (33) PC dispensing fees per recipient, per drug, per year. • A Reason LD (33) PC dispensing fee may not be claimed if titration is determined to be the basis for the "insufficient" dose. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LK (66) — Patient has been selected by the Medicaid Program to be locked-in to a physician and/or pharmacist based on information known about the patient's medical condition and use of excessive medication in a manner that may indicate drug abuse or diversion.	CC (21) — Pharmacist initiated contact with multiple prescribers to facilitate coordination of care. M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management. TC (15) — Pharmacist communicated with claims processor or state Medicaid program staff.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: LK-CC-1C LK-CC-1D LK-CC-1E LK-CC-1F LK-CC-1K LK-CC-2A LK-CC-3K LK-M0-1C LK-M0-1D LK-M0-1E LK-M0-1F LK-M0-1K LK-M0-2A LK-M0-3K LK-PE-2A LK-PE-3K LK-TC-2A LK-TC-3K	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Description of possible problem. • Name of person(s) contacted. • Summary of outcome, including summary of any communication with prescriber(s), patient, and other contact(s). • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of 15 Reason LK (66) PC dispensing fees per patient, per year. • This Reason code LK (66) when lock-in pharmacy manages patients enrolled in Medicaid's Recipient Lock-in Program. • Not billable for nursing home residents. • Level 14 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
LR (25) — Late refill requested. —Compliance problem suspected. —More than 25% after recipient should exhaust previously dispensed medication based on predicted days' supply.	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3M (80) — Compliance aid developed. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: LR-M0-1C+ LR-M0-1D+ LR-M0-1E+ LR-M0-1F+ LR-M0-1K+ LR-M0-2A LR-PE-3M+ LR-PE-3K+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Dates for previous two refills. • Expected date for this refill. • Number of days late; percent late on days' supply. • Determined reason for late refill. • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason LR (25) PC dispensing fees, per recipient, per year. • A PC dispensing fee may not be claimed under this code when the late refill is determined to be due to something other than a compliance problem (e.g., recipient had last refill filled elsewhere, previous early refill for convenience, previous lost refill found). • Do not use this code if abuse is suspected or documented. See Reason code DM (65). • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee. • Max PC dispensing fee: Level 13 on Action code M0, level 12 on Action code PE.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
MN (30) — Prescribed length of therapy may be shorter than minimum period recommended in medical literature for this recipient's condition. —Titration ruled out.	M0 (22) — Prescriber contacted.	1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: MN-M0-1D+ MN-M0-1F+ MN-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected length of therapy. • Source of minimum recommendation. • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason MN (30) PC dispensing fees per recipient, per drug, per year. • A Reason MN (30) PC dispensing fee may not be claimed if titration is determined to be the basis for the short length of therapy. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
MX (22) — Prescribed length of therapy exceeds expected length of therapy for this recipient's condition according to medical literature (abuse not suspected).	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: MX-M0-1C+ MX-M0-1D+ MX-M0-1E+ MX-M0-1F+ MX-M0-1K+ MX-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). • Time spent on documentation (minutes). • Identify drug. • Expected length of therapy. • Determined reason for prescribed length of therapy. • Outcome including summary of any communication with prescriber and recipient. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Prescriber contact required. • A maximum of two Reason MX (22) PC dispensing fees per recipient, per drug, per year. • Do not use this code if abuse is suspected or documented. See Reason Code DM (65). • Result Code 2A (30) can only be indicated when a replacement drug is not prescribed. • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee. Note: Titration or other dose adjustment must first be ruled out.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
NN (80) — The pharmacist determined continued therapy using a prescribed drug may not be necessary.	M0 (22) — Prescriber contacted.	2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.16 15-$40.16 ——————— Allowed PC dispensing fee code combinations: NN-M0-2A	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Summary of issue and therapeutic basis for recommendation. • Summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • List of discontinued drugs, if any. • R.Ph. identity. Limits: • A maximum of two Reason NN (80) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Not billable for nursing home residents. • Level 14 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
NS (32) — Prescribed quantity may be insufficient to treat this recipient's medical condition adequately according to medical literature. —Titration ruled out.	M0 (22) — Prescriber contacted.	1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ———————— Allowed PC dispensing fee code combinations: NS-M0-1D+ NS-M0-1F+ NS-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drug. • Minimum expected quantity. • Source of minimum recommendation. • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason NS (32) PC dispensing fees per recipient, per drug, per year. • A Reason NS (32) PC dispensing fee may not be claimed if titration is determined to be the basis for the "insufficient" quantity. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
PS (17) — Product selection opportunity.	TH (12) — Therapeutic interchange.* * Action requires prescriber authorization.	1E (14) — Orders filled with different drug.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 ——————— Allowed PC dispensing fee code combinations: PS-TH-1E+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify initial drug prescribed. • Summary of any communication with prescriber. • Changes made to drug(s), dose, frequency, directions, or quantity prescribed. • Indicate cost savings. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • Not to be used with drugs on the Medicaid Maximum Allowed Cost (MAC) list. • Not to be used for generic substitution. • May only be used when therapeutic interchange results in drug cost savings. • Level 14 = maximum PC dispensing fee. Note: The prescriber must be contacted for interchanges.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Level, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
RE (84) — In-home medication management.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan. CC (21) — Coordination of care. M0 (22) — Prescriber contacted. MR (23) — Comprehensive review and evaluation of the recipient's complete known medication regimen. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment or to develop skills and competencies related to its management.	3M (80) — Compliance aid developed. 3K (85) — Recipient demonstrates understanding of proper medication use.	Level-Fee 14-$40.11 Allowed PC dispensing fee code combinations: RE-AS-3M RE-CC-3K RE-M0-3K RE-MR-3K RE-PE-3M RE-PE-3K	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identification of drug(s) (when dispensed at same time as intervention). • Describe the medication management. • Describe the actions taken to solve the medication management problem and how it meets the recipient's needs. • Documentation of contact with physician ordering intervention. • Summarize the training provided to recipient in use of the medication. Include basis for recommendation. • R. Ph. identification. • Copy of physician order. • Describe the compliance aid developed and how it meets the recipient's needs. Limits: • A maximum of one Reason code RE (84) PC dispensing fee per recipient, per day. • Not available for nursing home residents or recipients receiving home health nurse services on the same days that services are billed by home health. • Service must be delivered by a pharmacist or other licensed health care professional. • Physician order is required. Note: Reason code 84 must always be billed at Level 14.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SC (83) — The recipient needs medication management assistance due to documented compliance problems.	AS (20) — Evaluation of information known by the pharmacist or supplied by the recipient for the purpose of developing a problem-based therapeutic plan.	3M (80) — The pharmacist designed, implemented, and provided recipient-specific training for a specific compliance aid program such as a "pill minder" or "punch card" system for in-home use.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$40.11 15-$40.11 Allowed PC dispensing fee code combinations: SC-AS-3M+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Describe the compliance problem, including the actual or potential negative recipient outcome of continued non-compliance. • Describe the compliance aid and how it meets the recipient's needs. • Summarize training provided to recipient in use of the compliance aid. • R.Ph. identity. Limits: • Not available for nursing home residents. • Maximum of two Reason SC (83) PC dispensing fees per recipient, per year. • Level 14 = maximum dispensing fee.

Appendix 7 continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SE (95) — The pharmacist determines it necessary to provide information regarding possible side effects of a drug prescribed for this recipient. Side effect precautions include: • Iatrogenic drug condition. • Drug-disease precaution. • Lactation precaution. • Drug-age precaution. • Drug-sex precaution. • Drug-food precaution. • Drug-lab precaution. • Drug-tobacco precaution. • Drug-alcohol precaution.	M0 (22) — Prescriber contacted. PE (25) — Verbal or written communication to the recipient by a pharmacist to enhance the recipient's knowledge about the condition under treatment, or to develop skills and competencies related to its management.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled. 3K (85) — Instructions understood.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SE-M0-1C+ SE-M0-1D+ SE-M0-1E+ SE-M0-1K+ SE-M0-2A SE-PE-3K+ + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Summary of intervention. • Summary of side effect precaution for this drug and recipient. • Identify drug not filled. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason SE (95) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when *no* replacement drug is prescribed. • Not billable for nursing home residents. • Level 13 = maximum PC dispensing fee if the prescriber is contacted. • Level 12 = maximum PC dispensing fee for patient education when the prescriber is not contacted. Note: Routine intervention is part of normal Prospective Drug Utilization Review (DUR) and consultation and is reimbursed under the "Traditional or Unit Dose" dispensing fee payment when the prescription is dispensed.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SF (34) — Prescribed dosage form may be incorrect, inappropriate, or less than optimal for treating this recipient.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SF-M0-1E+ SF-M0-1K+ SF-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Nature of problem with dosage form. • Identify drug. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason SF (34) PC dispensing fees per recipient, per drug, per year. • A Reason SF (34) PC dispensing fee may not be claimed if titration is determined to be the basis for the less-than-optimal therapy. • Level 13 = maximum PC dispensing fee.

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continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
SR (36) — Prescribed drug regimen may be incorrect or less than optimal for treating this recipient.	M0 (22) — Prescriber contacted.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1F (15) — Order filled with different quantity. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: SR-M0-1C+ SR-M0-1D+ SR-M0-1F+ SR-M0-1K+ SR-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify questioned drug(s). • Nature of problem with regimen. • Summary of and basis for recommendation(s). • Outcome including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of four Reason SR (36) PC dispensing fees per recipient, per year. • Result code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Appendix 7
continued

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
TD (59) — Recipient's drug regimen includes simultaneous use of one or more drugs with the same therapeutic effect or which contain identical generic chemical entities which may be inappropriate.	M0 (22) — Prescriber contacted.	1E (14) — Order filled with different drug. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$22.16 14-$22.16 15-$22.16 ——————— Allowed PC dispensing fee code combinations: TD-M0-1E+ TD-M0-2A + Requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Identify drugs. • Nature of multiple drug problem. • Summary of and basis for recommendation(s). • Outcome, including summary of any communication with prescriber and recipient. • Indicate if intervention was for safety, efficacy, compliance, or cost savings-only purposes. • ICD-9-CM for diagnosis, disease, or intended use of medication involved in the submitted intervention. • R.Ph. identity. Limits: • A maximum of two Reason TD (59) PC dispensing fees per recipient, per drug combination, per year. • Result Code 2A (30) may only be indicated when a replacement drug is *not* prescribed. • Level 13 = maximum PC dispensing fee.

Reason Code, Definition	Action Code, Definition	Result Code, Definition	Levels, Fees, PC Codes	Required Documentation and Limits (Providers must maintain a PC profile and include the following documentation. This documentation must be made available to Wisconsin Medicaid when requested.)
TN (85) — Based on medication profile review or recipient consultation, the pharmacist determined one or more laboratory tests should likely be performed.	RT (30) — The pharmacist recommends to the physician the performance of a clinical laboratory test for the recipient.	1C (12) — Order filled with different dose. 1D (13) — Order filled with different directions. 1E (14) — Order filled with different drugs. 1K (18) — Order filled with different dosage form. 2A (30) — Order not filled.	Level-Fee 11-$9.45 12-$14.68 13-$14.68 14-$14.68 15-$14.68 ——————— Allowed PC dispensing fee code combinations: TN-RT-1C+ TN-RT-1D+ TN-RT-1E+ TN-RT-1K+ TN-RT-2A + requires linked drug NDC, same DOS.	Document: • Date of intervention. • Professional time spent on intervention (minutes). Exclude documentation time. • Time spent on documentation (minutes). • Lab test recommended. • Summary of communication with the prescriber. • R.Ph. identity. Limits: • A maximum of one Reason TN (85) PC dispensing fee per recipient, per year. • Not billable for nursing home residents. • Level 12 = maximum PC dispensing fee.